OKLAHOMA OSTEOPATHIC PHYSICIAN AND SURGEON LICENSE APPLICATION PACKET

Dear Applicant:

The Oklahoma State Board of Osteopathic Examiners is pleased that you are interested in achieving licensure in the state of Oklahoma. As you can see from this packet, the process is lengthy. There are no shortcuts. The Board will review your application at one of the regularly-scheduled Board meetings before making a decision to grant you a license. The Board meets quarterly – the third Thursdays of March, June and September and the second Thursday of December.

Uniform Application fo Physician State Licensure (UA):

The Oklahoma State Board of Osteopathic Examiners was one of the first boards to incorporate the Uniform Application for Physician State Licensure (UA; formerly the CLA-F) into its application process. This form will make it easier for physicians to apply for licensure in additional states that utilize the UA. The OSBOE also requires completion of its Pre-Licensing Packet (PLP)

The Federation Credentials Verification Service (FCVS):

The Board highly recommends, but does not require, the use of FCVS to primary source verify core physician credentials as part of the licensure process. FCVS is a service of the Federation of State Medical Boards (FSMB) and was created to assist in license portability for physicians. Contact FCVS at 888-ASK-FCVS (888.275.3287) for additional information regarding the service and its fees and, if you have previously used their service, call FCVS to forward your credentials to the Oklahoma State Board of Osteopathic Examiners.

Important:

In planning your practice activity, allow an ample timeframe in order to achieve licensure. Our staff must have time to receive and process your application before it is presented to the Board and to determine if it is necessary for you to appear for a personal interview on Board meeting day. Applications not completed by the first day of each meeting month (March, June, September, or December) may not be presented for approval until the next quarterly meeting.

Even if using FCVS, you must still apply for licensure in the State of Oklahoma by submitting the UA, the Oklahoma Pre-Licensing Packet, a licensure application fee of $575.00, and certain other documentation. To ensure that the process goes well, we suggest you follow the enclosed instructions carefully and completely. Should you have questions regarding the application form or process, feel free to contact the Board office for assistance.

Sincerely,

Christi Aquino / Brandon Gambill
Licensure Specialists
OKLAHOMA STATE BOARD OF OSTEOPATHIC EXAMINERS
4848 North Lincoln Boulevard, Suite 100
Oklahoma City, OK 73105
405.528.8625

EXHIBIT 13

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Send this form to the Program Director of your postgraduate training program.

Applicants not using FCVS:

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Section 1: Applicant Information

Last name: _____ Suffix: _____

First name: _____

Middle name: _____

Name if different when diploma awarded: _____

Name of postgraduate training program: _____

Date of birth: _____ Social Security number*: _____

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

In listing the Board information below, please reference http://www.fsmb.org/directory_smb.html.

Name of Board applying to: Oklahoma State Board of Osteopathic Examiners

Board address: 4848 N. Lincoln Blvd., Suite 100

Board city/state/zip code: Oklahoma City, OK 73105-3335

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed above. I request that the Program Director or designated official complete Section 2 of this form and send it to the Board listed above at the given address.

Applicant signature: _____ **Date**: _____

Program Director or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty and provide a schedule of rotations if the specialty/subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the board listed in Section 1 with any added documentation, if applicable.

Section 2: Postgraduate Training Verification

Institution name: _____

Institution address: _____

Institution city / state or province / zip code: _____

Affiliated medical school name: _____

Institution / school name if different when the applicant attended: _____

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Applicant Name: _____

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Postgraduate year (e.g., 1, 2, 3, etc.): _____ ☐ Internship ☐ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: _____

Attendance dates: From _____ to _____

Successfully completed*? ☐ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☐ No
2. Was this individual ever placed on probation? ☐ Yes ☐ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☐ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☐ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? ☐ Yes ☐ No

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____
Print name: _____
Title: _____
Date: _____
Phone number: _____ Fax number: _____
Email: _____

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)